Diphtheria

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Investigation Information

* indicates required fields

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	First Name*	Middle Initial

Street Address

City	County	State	Zip
		West Virginia	

Is the patient's residence a:

○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____

○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.	Report Date mm/dd/yyyy

Parent / Guardian Information

Last Name	First Name	Middle Initial	Relationship to Patient

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	County	State	Zip
		West Virginia	

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	Age	Age Units
		○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Patient Demographic Information cont.

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native* ☐ *Asian*
☐ *Black or African American* ☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White* ☐ *Unknown*
☐ *Failure to report race/missing race* ☐ *Some Other Race*_____

Outcome and Clinical Information

Clinical Information

Date of onset of symptoms mm/dd/yyyy

Date of diagnosis mm/dd/yyyy

Was patient hospitalized for this disease?

○ *Yes* ○ *No* ○ *Unknown*

Name of Hospital

Date of Admission mm/dd/yyyy

Symptoms

Symptoms

○ *Fatigue* ○ *Other (specify):*_____ ○ *Sore Throat* ○ *Difficulty swallowing*
○ *Change in voice* ○ *Shortness of breath* ○ *Weakness*

Membrane present?

○ *Yes* ○ *No* ○ *Unknown*

If membrane present, sites

(Check all that apply)

☐ *Conjunctiva* ☐ *Hard Palate* ☐ *Larynx* ☐ *Nares* ☐ *Nasopharynx* ☐ *Skin* ☐ *Soft Palate* ☐ *Tonsils*

Signs

Fever?

○ *Yes* ○ *No* ○ *Unknown*

If yes, temperature: (Degrees F)

Soft tissue swelling? (Around membrane)

○ *Yes* ○ *No* ○ *Unknown*

Neck edema?

○ *Yes* ○ *No* ○ *Unknown*

Neck edema, if Yes

○ *Bilateral* ○ *Left side only* ○ *Right side only*

Neck edema, if Yes

○ *Submandibular* ○ *Midway to clavicle* ○ *To clavicle* ○ *Below clavicle*

Stridor

○ *Yes* ○ *No* ○ *Unknown*

Wheezing

○ *Yes* ○ *No* ○ *Unknown*

Palatal weakness

○ *Yes* ○ *No* ○ *Unknown*

Tachycardia

○ *Yes* ○ *No* ○ *Unknown*

EKG abnormalities

○ *Yes* ○ *No* ○ *Unknown*

Description of Clinical Picture

Outcome

Outcome

○ *Recovered, No residue* ○ *Recovered, Residue* ○ *Died* ○ *Unknown*

Complications

Complications?

○ *Yes* ○ *No* ○ *Unknown*

Airway obstruction?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date of onset mm/dd/yyyy

Intubation required

○ *Yes* ○ *No* ○ *Unknown*

Myocarditis?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date of onset mm/dd/yyyy

(Poly)neuritis?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date of onset mm/dd/yyyy

Other

○ *Yes* ○ *No* ○ *Unknown*

If Other, Describe

Laboratory Data

Specimen for diphtheria culture obtained?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, date specimen collected mm/dd/yyyy

Result Date mm/dd/yyyy

Culture result

○ *Positive* ○ *Negative* ○ *Not Done*

Laboratory Data cont.

Specify lab performing culture:
###-###-####

If culture positive, biotype:
○ *Belfanti* ○ *Gravis* ○ *Intermedius* ○ *Mitis*

If culture positive, results of toxigenicity testing
○ *Negative* ○ *Positive* ○ *Unknown* ○ *Not Done*

Specimen sent to CDC Diphtheria Lab for confirmation/molecular typing
○ *Yes* ○ *No* ○ *Will be Sent*

Type of specimen
○ *Clinical swab* ○ *Piece of membrane* ○ *C. diptheriae isolate*

Serum Specimen for Diphtheria Antitoxin Antibodies Obtained?
○ *Yes* ○ *No* ○ *Unknown*

PCR Result:
○ *Positive* ○ *Negative* ○ *Unknown* ○ *Not Done*

As an Outpatient

Treated with Antibiotics
○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date initiated
mm/dd/yyyy

Duration of Therapy
(days)

Antibiotic Therapy given as Outpatient
(Check all that apply)

☐ *Erythromycin (incl. pediazole, ilosone)*
☐ *Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixme*
☐ *Cotrimoxazole (bactrim/septra)*
☐ *Other (specify):*_____
☐ *Penicillin (Bicillin, Pfizerpen-AS, Wycillin)*
☐ *Clarithromycin/azithromycin*
☐ *Tetracycline/Doxycycline*
☐ *Unknown*

As an Inpatient

Treated with Antibiotics
○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date initiated
mm/dd/yyyy

Duration of Therapy
(days)

Antibiotic Therapy given in Hospital
(Check all that apply)

☐ *Erythromycin (incl. pediazole, ilosone)*
☐ *Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixme*
☐ *Cotrimoxazole (bactrim/septra)*
☐ *Other (specify):*_____
☐ *Penicillin (Bicillin, Pfizerpen-AS, Wycillin)*
☐ *Clarithromycin/azithromycin*
☐ *Tetracycline/Doxycycline*
☐ *Unknown*

Were Antibiotics given in the 24 hours before culture?
○ *Yes* ○ *No* ○ *Unknown*

DAT Administered
○ *Yes* ○ *No*

Amount of DAT Administered
IU DAT

Laboratory Name

Phone
###-###-####

Ext.

Fax Number
###-###-####

Address

State:
West Virginia

Zip:

Reporting Source

Last Name

First Name

Phone
###-###-####

Ext.

Fax
###-###-####

Facility

Address

City

State
West Virginia

Zip

E-mail

Provider with Further Patient Information

Last Name	First Name	
Phone ###-###-####	**Ext.**	**Fax** ###-###-####
Address		
City	**State** West Virginia	**Zip**

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy
Investigator	**Date public health investigation began** mm/dd/yyyy	**Health Department** / **Phone** ###-###-####
Ext.		

Investigation ID	Part of an Outbreak?	Outbreak Name	Lost to follow-up?
	○ Yes ○ No ○ Unknown		○ Yes ○ No

Country of Residence	If Other, Country Name	Date of U.S. Arrival
○ US ○ Other_____		mm/dd/yyyy

History of International Travel
(2 weeks prior to onset)
○ Yes ○ No ○ Unknown

Country Visited	From	To
Select Country	mm/dd/yyyy	mm/dd/yyyy

History of Interstate Travel
(2 weeks prior to onset)
○ Yes ○ No ○ Unknown

State Visited	From	To
Select State	mm/dd/yyyy	mm/dd/yyyy

Known Exposure to Diphtheria Case or Carrier?	Known Exposure to International Travelers?	Known Exposure to Immigrants?
○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown

History of Immunization against Diphtheria

Childhood Primary Series	If < 18 years old, number of doses	Boosters as Adult	Date of last Dose mm/dd/yyyy	Date Dosed ☐ Unknown
○ Yes ○ No ○ Unknown		○ Yes ○ No ○ Unknown		

Physician Requesting D.A.T.

Name

Institution

Street	**City**	**State**
		West Virginia

Zip Code	**Phone** ###-###-####	**Fax** ###-###-####

Name of Investigator under IND (if different from requesting physician)

Name	**Phone** ###-###-####	**Fax** ###-###-####

Ship Drug To:

Name

Institution

Street	**City**	**State**
		West Virginia

Zip Code	**Phone** ###-###-####	**Fax** ###-###-####

Diphtheria Close Contacts Information

Name	**Age**	**Relation to the Case**

Vaccinated	**If Vaccinated, number of lifetime doses**	**Last Dose**
○ *Yes* ○ *No* ○ *Unknown*		○ *5 Yrs Ago* ○ *> 5 Yrs Ago*

Nasopharyngeal Culture Obtained	**If Yes, Date of Culture** mm/dd/yyyy	**Results**
○ *Yes* ○ *No* ○ *Unknown*		○ *Positive* ○ *Negative* ○ *Unknown*

Oropharyngeal (Throat) Culture Obtained	**If Yes, Date of Culture** mm/dd/yyyy	**Results**
○ *Yes* ○ *No* ○ *Unknown*		○ *Positive* ○ *Negative* ○ *Unknown*

Antibiotic Prophylaxis
(Check all that apply)

☐ *Erythromycin (incl. Pediazole, ilosone)*
☐ *Penicillin (Bicillin, Pfizerpen-AS, Wycillin)*
☐ *Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixme*
☐ *Clarithromycin/azithromycin*
☐ *Cotrimoxazole (bactrim/septra)*
☐ *Tetracycline/Doxycycline*
☐ *Other*_____
☐ *Unknown*

Diphtheria Close Contacts Information cont.

Name | **Age** | **Relation to the Case**

Vaccinated
○ *Yes* ○ *No* ○ *Unknown*

If Vaccinated, number of lifetime doses

Last Dose
○ *5 Yrs Ago* ○ *> 5 Yrs Ago*

Nasopharyngeal Culture Obtained
○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date of Culture
mm/dd/yyyy

Results
○ *Positive* ○ *Negative* ○ *Unknown*

Oropharyngeal (Throat) Culture Obtained
○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date of Culture
mm/dd/yyyy

Results
○ *Positive* ○ *Negative* ○ *Unknown*

Antibiotic Prophylaxis
(Check all that apply)

☐ *Erythromycin (incl. Pediazole, ilosone)* ☐ *Penicillin (Bicillin, Pfizerpen-AS, Wycillin)* ☐ *Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixme*
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☐ *Other*_____ ☐ *Unknown*

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○ *Yes* ○ *No* ○ *Unknown*

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○ *Yes* ○ *No* ○ *Unknown*

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mm/dd/yyyy

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☐ *Other*_____ ☐ *Unknown*

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○ *Yes* ○ *No* ○ *Unknown*

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Last Dose
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○ *Yes* ○ *No* ○ *Unknown*

If Yes, Date of Culture
mm/dd/yyyy

Results
○ *Positive* ○ *Negative* ○ *Unknown*

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☐ *Clarithromycin/azithromycin* ☐ *Cotrimoxazole (bactrim/septra)* ☐ *Tetracycline/Doxycycline*
☐ *Other*_____ ☐ *Unknown*

Diphtheria Close Contacts Information cont.

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○ *Yes* ○ *No* ○ *Unknown*		○ *5 Yrs Ago* ○ *> 5 Yrs Ago*

Nasopharyngeal Culture Obtained	If Yes, Date of Culture mm/dd/yyyy	Results
○ *Yes* ○ *No* ○ *Unknown*		○ *Positive* ○ *Negative* ○ *Unknown*

Oropharyngeal (Throat) Culture Obtained	If Yes, Date of Culture mm/dd/yyyy	Results
○ *Yes* ○ *No* ○ *Unknown*		○ *Positive* ○ *Negative* ○ *Unknown*

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(Check all that apply)

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☐ *Clarithromycin/azithromycin*
☐ *Cotrimoxazole (bactrim/septra)*
☐ *Tetracycline/Doxycycline*
☐ *Other*_____
☐ *Unknown*

Describe Public Health Action Taken